New Jersey Department of Human Services
Division of the Deaf and Hard of Hearing

NEW JERSEY HEARING AID PROJECT
Eligibility Application, Form A

Important Note:

Form A is to be used only by individuals registered with the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program.

2015 Income Limits: Single: less than $26,575; Married: less than $32,582

SECTION 1 & 2: TO BE COMPLETED BY APPLICANT

1. Enter your PAAD number, name, date of birth and sex. List your Social Security number. Use CAPITAL LETTERS. Print only one letter or number in each box. List date of birth verified by Social Security.

PAAD Number

Last Name

Suffix (Jr., Sr., etc.)

First Name

Middle Initial

Sex **M**ale/**F**emale

Month / Day / Year

Social Security Number ___ - ___ - ____

Date of Birth ___/___/____

2. Enter your Home Address and Phone Number.

Address

City

State

Zip Code ____ - ____

Phone ___ ___ - ____

see other side

SECTION 3: TO BE COMPLETED BY PHYSICIAN OR LICENSED AUDIOLOGIST

I have examined this applicant and determined the necessity of a hearing aid.

_____ Telephone (_____)_____

Name of Physician or Licensed Audiologist (Print)

_____

Address of Physician or Licensed Audiologist

_____Date_____

Signature of Physician or Licensed Audiologist

APPLICANTS CERTIFICATION AND WAIVER

I certify that the information above is true and accurate to the best of my knowledge. I understand that if it is determined that benefit has been improperly issued to me, I will be required to repay such benefit. I understand to verify my eligibility for NJHAP it may be necessary to obtain certain information from the records of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program, and I authorize release of that information. I hereby assign to the State of New Jersey any right to hearing aid coverage to which I may be entitled under any other plan of assistance or insurance from any other liable third party. I certify that I do not currently own a hearing aid appropriate for my hearing loss.

_____ _____

Signature of Applicant Date

DO NOT WRITE BELOW THIS LINE

For Office Use only

Yes.. ☐ Verified by _____ Date _____

No.. ☐

Return form to:
DDHH
New Jersey Hearing Aid Project
PO Box 074, Trenton, NJ 08625-0074
Or (609) 588-2528 Fax
For more information call 609-588-2648; 800-792-8339; 609-503-4862 VP